EXHIBIT “A”

NEOS

NEW ENGLAND ORTHOPEDIC SURGEONS

Louis M. Adler, MD
Hand, Wrist & Elbow Surgery
Wrist Arthroscopy
J. Stephen Brecht, MD
Trauma and Fracture Care
Complex Fractures
Bennett S. Burns, MD
Trauma & Fracture Care
Complex Fractures
John R. Corsetti, MD
Sports Medicine/Arthroscopy
Shoulder & Knee Surgery
R. Scott Cowan, MD
Spine Surgery
Richard J. Fingeroth, MD
Joint Replacement Surgery
Sumner E. Karas, MD
Shoulder Surgery & Arthroscopy
Robert J. Krushell, MD
Joint Replacement Surgery
Andrew P. Lehman, MD
Joint Replacement Surgery
Martin J. Luber, MD
Sports Medicine/Arthroscopy
Shoulder, Knee & Elbow Surgery
Thomas A. McDonald, MD
Foot & Ankle Surgery
Lois Ann Nichols, MD
Trauma & Fracture Care
Complex Fractures
Joseph H. Sklar, MD
Sports Medicine/Arthroscopy
Knee Surgery
Steven M. Wenner, MD
Hand & Wrist Surgery

Jason J. Asselin, PA-C
Tamer Bahgat, PA-C
Henry J. Casagrande Jr. PA-C
Michael D. Cavanagh, PA-C
Jessica M. Drenga, APRN
Mark A. Durille, PA-C
Beverly Faille, APRN
Kevin MacPherson, PA-C
Peter A. Michaud, PA-C
Melissa Mol-Pelton, PA-C
Anika Opp-Harris, PA-C
Edward A. Pacitti, PA-C
Tracey A. Rauenberg, PA-C
Timothy B. Rice, PA-C
Donald C. Salva, PA-C
Amy Warrington, PA-C
Miriam K. Wiggins, PA-C

Executive Director Chris Dugger

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April 26, 2010

Thomas J. Joyce, III
801 Centerton Road
Mt. Laurel, NJ 08054

RE: Geoffrey Crowther
DOB: [redacted]
OUR ACCT [redacted]0

Dear Mr. Joyce:

As you are aware, Mr. Geoffrey Crowther has been under the care of myself, Dr. Martin Luber, of New England Orthopedic Surgeons. Mr. Crowther originally sought care with my office regarding issues related to left elbow pain in 2007. I originally had the opportunity to evaluate Mr. Crowther in February of 2007. Prior to that, he was cared for in our offices by Dr. Wenner, Dr. Adler, and Dr. Cowan. He was referred for mechanical locking episodes of left elbow pain to myself.

At the time of his initial presentation, he had what appeared to be early degenerative osteoarthropathy of his left elbow, and loose bodies. A CT scan was obtained by myself to document these findings and they were confirmed. Mr. Crowther was able to manage his symptoms conservatively, at least at that juncture. He required significant other orthopedic interventions including undergoing total knee arthroplasties in April of 2007. He eventually returned to my care regarding his ongoing left elbow issues in early 2009. His other orthopedic issues had been treated appropriately and he was now able to focus his attention on his ongoing persistent left elbow mechanical locking episodes.

The patient underwent a left elbow diagnostic and operative arthroscopy with debridement and loose body removal. He has been able to recover not only range of motion, but has better comfort and most importantly, elimination of his mechanically locking episodes post-operatively. The

Thomas J. Joyce, III
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elbow arthroscopy was performed by myself on Mr. Crowther on February 27, 2009. Mr. Crowther was appropriately treated with physical therapy post-operatively and has regained near full range of motion. We would not expect Mr. Crowther to return to his previous level of employment given his multiple other orthopedic issues including bilateral total knee arthroplasties, left shoulder rotator cuff injury, left elbow degenerative osteoarthropathy.

Question placed to me as to whether or not Mr. Crowther's left elbow injury was specifically related to his employment. I have had the opportunity to review the work requirements of Mr. Crowther's job at CSX. I believe that Mr. Crowther's repetitive use of his left upper extremity including lifting, carrying, hammering, etc., is in fact a direct cause if not an exacerbating feature of the development of left elbow degenerative osteoarthropathy. To a reasonable degree of medical certainty, I believe that Mr. Crowther's work habits as described to me, and available from description by CSX Industries, would in fact increase the likelihood that Mr. Crowther would develop degenerative osteoarthropathy of his left elbow and result in mechanical symptoms associated with loose bodies. I believe that Mr. Crowther has had appropriate medical management for his left elbow issues including operative intervention and postoperative physical therapy.

At this time, I believe that to a reasonable degree of medical certainty that Mr. Crowther's left elbow injury was exacerbated and aggravated, and at least partially caused by his work history at CSX Transportation.

Should you have any additional questions regarding Mr. Crowther's ongoing issues regarding his left elbow, do not hesitate to call.

Signed and sworn to under the pains and penalties of perjury this 27 day of April 2010.

Sincerely,

Martin J. Luber, M.D.

MJL/hh

GEOFFREY CROWTHER 05/07/1951

199336.0

March 19, 2007 LUBER/um: Mr. Crowther is here for an evaluation and recheck on his left elbow. CT scan is available for our review today. It reveals early degenerative osteoarthropathy, multiple intra-articular loose bodies, what appears to be an old OCD lesion on the posterior surface of the humeral capitellum. Today, he has relatively few symptoms because, again, his work habits have changed. He is about to undergo total knee arthroplasty as well as remaining in a short-arm cast from recent left wrist surgery with Dr. Wenner.

Today on physical examination, well-appearing gentleman, alert and oriented x 3 with a pleasant affect. LEFT ELBOW lacks about 5 degrees of full extension, flexes to about 130 degrees today. No significant radiocapitellar crepitus. No varus or valgus instability. No warmth, redness or erythema. No significant medial or lateral epicondylar pain today. No mechanical symptoms associated with his exam today.

The CT scan is as above.

IMPRESSION:

1. Early degenerative osteoarthropathy of the left elbow.
2. Left knee loose bodies.
3. Left knee capitellar old osteochondritis dissecans lesion.

PLAN: Based upon the deformity of his capitellum, I would recommend an open arthrotomy for loose body removal as well as radial head resection. I think that this offers him the best expectations of long-term success for not only his osteoarthropathy, but also his loose bodies. I would be concerned that simple arthroscopy with removal of loose bodies, but no treatment of his OCD lesion may leave him with ongoing symptoms. He will consider his options, await his upcoming bilateral total knee arthroplasty, and check back with me thereafter.

GEOFFREY CROWTHER 05/07/1951

199336.0

March 27, 2007 PACITTI/WENNER/ndd: This gentleman is approx. six weeks s/p arthrodesis MCP joint left thumb. He has been immobilized in a cast.

Today, his cast was removed.

PE: He is fully ambulatory. His vital signs are stable. He has full ROM of the shoulders, elbows, forearms. The right hand has full digital motion, the left hand is notable for a well-healed surgical scar which is Steri-Striped at the dorsum of the thumb MPJ. There are two pins in place. The pin sites are clean and dry. There is stability at the fracture site without pain and stress at the fusion site. Distal circulation and sensation is intact.

X-RAY REPORT: Radiographs ordered and reviewed today of the left thumb in three projections, demonstrates stable position of arthrodesis with two pins in place. There is no abundance of periosteal bone reaction.

His pins were removed today without difficulty. He is going to have a custom molded splint fabricated and is instructed in use of the splint and early ROM of the basilar joint and IPJ of the thumb. He will recheck in a month.

GEOFFREY CROWTHER 05/07/1951

199336.0

January 19, 2009 LUBER/aet: Mr. Crowther is here for a recheck on his left knee. I have not seen him in 18 months. Previously diagnosed with intra-articular loose bodies of his left elbow. He has been having ongoing mechanical symptoms and discomfort as he is recovering from bilateral total knee arthroplasty and cervical spine decompression and fusion. He would like to see if he can have appropriate definitive surgical correction for his left elbow issues.

On exam he achieves full extension, flexes to 135 or 140, fully pronates, fully supinates, no varus or valgus instability. He has crepitus with radiocapitellar space today. 5/5 biceps and triceps strength. No evidence of elbow instability. No medial or lateral epicondylar pain today.

IMPRESSION: Intra-articular loose body confirmed by today's radiographic structures. It seems to be primarily in the anterior compartment of his left elbow. We discussed whether or not we could manage his symptoms with an intra-articular injection, which may be temporary, but might be helpful. He was not interested in pursuing that. He was interested in pursuing definitive surgical correction with a left elbow arthroscopy for loose body removal. We discussed the postoperative care and management and expectations of that surgery. He is interested in pursuing that and will contact Angie to schedule.